THE DESTRUCTIVE IMPACT OF DRUGS ON THE UNITED STATES: HOW THE LEGALIZATION OF DRUGS WOULD JEOPARDIZE THE HEALTH AND SAFETY OF THE AMERICAN PEOPLE AND OUR NATION

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INTRODUCTION

Given the negative impact of drugs on American society, the overwhelming majority of Americans reject illegal drug use. Indeed millions of Americans who once tried drugs now turn their backs on them -- they no longer "do drugs," and most importantly, don't want their children doing them. While most Americans steadfastly reject drugs, small elements of the social spectrum argue that prohibition -- and not drugs -- creates the problems we face. These people offer solutions in various guises, ranging from outright legalization to so-called "harm reduction." In fact, all drug policies seek to reduce the harms of drug use. No rational approach would seek to increase harms to families, children and our nation. The real question is: what policies actually do the most to decrease the harms drugs cause?

Part I of this monograph provides an **overview** of what proponents of **legalization** really want to achieve through their efforts, namely: legalization of not only marijuana, but other more dangerous drugs such as heroin and cocaine. **Part II** of this monograph cuts through the haze of this misinformation to **expose the fallacies and realities of** what **legalization** would mean to this nation, namely: significantly higher rates of drug abuse, particularly among young people, and exponentially increased human and social costs to our society. **Part III** of this monograph sets out the **balanced approach** to fighting drugs provided in our ***National Drug Control Strategy.*** This part summarizes how we intend to reach our goal of cutting drug use and its consequences in America by half over the next ten years.

I. WHAT PROPONENTS OF LEGALIZATION REALLY WANT: EASY ACCESS TO ALL DRUGS OF ABUSE

Our nation's democratic system of government is founded upon free and open debate. Our nation holds no beliefs or icons above challenge and examination. We all must be willing to lay the facts and our analysis on the table of public scrutiny, and make the case for what we believe.

However, in the marketplace of ideas, just as in other marketplaces, there are people willing to use deceptive claims, half truths and flawed logic to hawk ill-considered beliefs. Nowhere is this problem more clear than with respect to the drug legalization movement.

Proponents of legalization know that the policy choices they advocate are unacceptable to the American public. Because of this, many advocates of this approach have resorted to concealing their real intentions and seeking to sell the American public legalization by normalizing drugs through a process designed to erode societal disapproval.

For example, ONDCP has expressed reservations about the legalization of hemp as an agricultural product because of the potential for increasing marijuana growth and use. While legitimate hardworking farmers may want to grow the crop to support their families, many of the other proponents of hemp legalization have not been as honest about their goals. A leading hemp activist, is quoted in the *San Francisco Examiner* and on the Media Awareness Project's homepage (a group advocating drug policy reforms) as saying he "can't support a movement or law that would lift restrictions from industrial hemp and keep them for marijuana."[1] If legalizing hemp is solely about developing a new crop and not about eroding marijuana restrictions, why does this individual only support hemp deregulation if it is linked to the legalization of marijuana?

Similarly, when Ethan Nadelmann Director of the Lindesmith Center (a drug research institute), speaks to the mainstream media, he talks mainly about issues of compassion, like medical marijuana and the need to help patients dying of cancer. However, Mr. Nadelmann's's own words in other fora reveal his underlying agenda: legalizing drugs. Here is what he advocates:

> *Personally, when I talk about legalization, I mean three things: the first is to make drugs such as marijuana, cocaine, and heroin legal . . . .*[2]

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[1]Katherine Seligman, *Legalization Sought for Cousin of Pot,* San Francisco Examiner, May 9, 1999, C1 (quoting hemp activist Jack Herer).

[2]Ethan Nadelmann, *Should Some Drugs Be Legalized?*, 6 Issues in Science and Technology 43-46 (1990).

I propose a mail order distribution system based on a right of access . . . .[3]

Any good non-prohibitionist drug policy has to contain three central ingredients. First, possession of small amounts of any drug for personal use has to be legal. Second, there have to be legal means by which adults can obtain drugs of certified quality, purity and quantity. These can vary from state to state and town to town, with the Food and Drug Administration playing a supervisory role in controlling quality, providing information and assuring truth in advertising. And third, citizens have to be empowered in their decisions about drugs. Doctors have a role in all this, but let's not give them all the power.[4]

We can begin by testing low potency cocaine products -- coca-based chewing gum or lozenges, for example, or products like Mariani's wine and the Coca-Cola of the late 19th century -- which by all accounts were as safe as beer and probably not much worse than coffee. If some people want to distill those products into something more potent, let them.[5]

But if there is a lot of PCP use in Washington, then the government comes in and regulates the sale.[6]

Mr. Nadelmann's view that drugs, including heroin and other highly addictive and dangerous drugs, should be legalized are widely shared by this core group of like-minded individuals. For example, Mr. Arnold Trebach states:

Under the legalization plan I propose here, addicts . . . would be able to purchase the heroin and needles they need at reasonable prices from a non-medical drugstore.[7]

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[3]Ethan Nadelmann, *Thinking Seriously About Alternatives to Drug Prohibition,* 121 Daedalus 87-132 (1992).

[4]Ethan Nadelmann and Jan Wenner, *Toward a Sane National Drug Policy,* Rolling Stone May 5, 1994, 24-26.

[5]*Id.*

[6]Ethan Nadelmann, *How to Legalize, interview with Emily Yoffe,* Mother Jones, Feb./Mar. 1990, 18-19.

[7]Arnold Trebach & James Inciardi, Legalize It? Debating American Drug Policy, 109-110 (1993).

International financier George Soros, who funds the Lindesmith Center, has advocated: "If it were up to me, I would establish a strictly controlled distributor network through which I would make most drugs, excluding the most dangerous ones like crack, legally available."[8] William F. Buckley, Jr. has also called for the "legalization of the sale of most drugs, except to minors."[9]

Similarly, when the legalization community explains their theory of harm reduction -- the belief that illegal drug use cannot be controlled and, instead, that government should focus on reducing drug-related harms, such as overdoses -- the underlying goal of legalization is still present. For example, in a 1998 article in *Foreign Affairs*, Mr. Nadelmann expressed that the following were legitimate "harm reduction" policies: allowing doctors to prescribe heroin for addicts; employing drug analysis units at large dance parties, known as raves, to test the quality of drugs; and "decriminalizing" possession and retail sale of cannabis and, in some cases, possession of "hard drugs."[10]

Legalization, whether it goes by the name harm reduction or some other trumped up moniker, is still legalization. For those who at heart believe in legalization, harm reduction[11] is too often a linguistic ploy to confuse the public, cover their intentions and thereby quell legitimate public inquiry and debate. Changing the name of the plan doesn't constitute a new solution or alter the nature of the problem.

In many instances, these groups not only advocate public policies that promote drug use, they also provide people with information designed to encourage, aid and abet drug use. For example, from the Media Awareness Project (a not-for-profit organization whose self-declared mission is to encourage a re-evaluation of our drug policies) website a child can "link" to a site that states:

> *Overgrow the Government!*
> *Grow your own stone! It's easy! It's fun! Everybody's doing it!*
> *Growing marijuana: a fun hobby the whole family can enjoy!*[12]

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[8]George Soros, Soros on Soros, p. 200 (1995).

[9]William F. Buckley, *The War on Drugs is Lost,* National Review, Feb. 12, 1996, 35-48.

[10]*See* Ethan Nadelmann, *Commonsense Drug Policy,* 77 Foreign Affairs 111-126 (1998).

[11]It should, however, be emphasized that not all advocates of harm reduction support drug legalization. Nor, does harm reduction, by itself, require legalization. In fact, aspects of the *National Drug Control Strategy*, such as methadone treatment, properly adopt harm reduction programs as part of a comprehensive, balanced approach to reducing drug use. Nevertheless, the fact remains that many who advocate harm reduction use it as a subterfuge for legalization.

[12]*See* "www.cannabisculture.com/grow".

The linked website goes on to provide the reader with all the information needed to grow marijuana, including a company located in Vancouver, Canada that will ship seeds or plants.

The Media Awareness Project website also includes links to instructions about how drug users can defeat drug tests.[13] Similarly, the websites of both the Drug Policy Foundation, a self-proclaimed drug policy reform group, and the Media Awareness Project, both provide links to a site that gives instructions for how to manufacture the drug "ecstasy."[14]

Careful examination of the words -- speeches, webpostings, and writings -- and actions of many who advocate policies to "reduce the harm" associated with illegal drugs reveals a more radical intent. In reality, their drug policy reform proposals are far too often a thin veneer for drug legalization.[15]

What do drug "legalizers" truly seek? They want drugs made legal -- even though this would dramatically increase drug use rates. They want drugs made widely available, in chewing gums and sodas, over the Internet and at the corner store -- even though this would be tantamount to putting drugs in the hands of children. They want our society to no longer frown on drug use –

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[13] *See* "www.mapinc.org" ("drug links" 7 and 8 link to the following two websites: "www.hightimes.com/ht/tow/tes/index.html" and "www.cannabisculture.com/usage/dtfaq.shtml").

[14] *See* "www.mapinc.org", which includes as part of its site "www.mapsorg/news.html", which then links to "www.ecstacy.org/links/index.html", which then includes "www.hyperreal.org/~lamont/pharm/faq/faq-mdma-synth.html". This same information is also found on "www.lyceum.org/drugs/synth . . ./mdma/synthesis/mdma.mda.synthesis".

[15] *See* Richard Cowan, *Building a New NORML,* High Times, Jan. 1993, p. 67. Mr. Cowan has made clear how harm reduction policies fit into the legalization agenda as follows:

> Based on our objective of "Legalization by 97" we must begin by demanding: 1 -- immediate access to marijuana for the sick. 2 -- The immediate cessation of all attacks on users, growers and sellers of marijuana. 3 -- An immediate end to lying about marijuana and its users. 4 -- Recognition of the economic and environmental importance of hemp, and studies on how it can be best exploited by American agriculture and industry.

Id.

even though each year drug use contributes to 50,000 deaths[16] and costs our society $110 billion in social costs.[17] And, they want the government to play the role of facilitator, handing out drugs like heroin and LSD.

Let me emphasize, there is nothing wrong with advocating for change in public policy. From civil rights to universal suffrage, much of what makes our nation great has been the result of courageous reform efforts. Our nation benefits from the airing of dissent. However, we all have a responsibility to be honest in debate about our motives. We all have an obligation to be open with the American people about the risks inherent in what we advocate. To date, advocates of legalization have not been so forthcoming.

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[16]CSR Inc., unpublished research prepared for ONDCP, 1999.

[17]NIDA and NIAAA, *The Economic Costs of Alcohol and Drug Abuse in the United States, 1992*, NIDA/NIH pub. no. 98-4327, Sept. 1998.

II. THE FALLACIES AND REALITIES OF DRUG LEGALIZATION

FALLACY: There is a large movement to legalize drugs in America.

REALITY: THERE IS NO SUCH THING AS A DRUG LEGALIZATION "MOVEMENT" IN AMERICA.

One recent account placed the number of groups advocating drug policy reform at roughly four-hundred nation-wide, including local chapters of national organizations.[18] By contrast, there are roughly 1,300 local chapters of the American Red Cross; 3,400 units of the American Cancer Society; 9,000 Veterans of Foreign Wars posts; 2,351 local YMCA chapters; 121,948 local Boy Scouts Units; and, 4,300 Community Anti-Drug Coalitions. The "Prevention Through Service Alliance" alone, established by ONDCP, brings together forty-seven national civic, service, fraternal, veterans, and women's organizations, representing one hundred million people and nearly one million local chapters, in a coordinated effort to reduce youth drug use. These organizations are at the forefront of real movements -- to safeguard lives and health, to honor those who served our nation, to end the plague of cancer, to mentor young people, and to protect our youth from drugs. By this standard there is no movement in America to legalize drugs.

There is, however, a carefully-camouflaged, well-funded, tightly-knit core of people whose goal is to legalize drug use in the United States. It is critical to understand that whatever they say to gain respectability in social circles, or to gain credibility in the media and academia, their common goal is to legalize drugs.

FALLACY: Americans increasingly support drug legalization.

REALITY: RIGHTFULLY, THE AMERICAN PUBLIC OPPOSES DRUG LEGALIZATION.

The American people understand the risks that drug legalization would entail and overwhelmingly reject this ill-considered approach. Youth access to and use of alcohol and cigarettes is bad enough -- American parents clearly don't want children able to use a fake ID at the corner store to buy heroin. We have enough problems with drinking and driving -- families don't want to live in fear that the driver of the eighteen wheeler motoring alongside their minivan is high on marijuana, methamphetamines or LSD. Thousands of our loved ones already die from drug-related causes -- reasonable people don't want drugs to be accessible over the Internet.

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[18] *See* Ken Kraysee, *Pot Politics,* Hartford Advocate, May 20, 1999. The Drug Reform Coordination Network's website claims just 6,000 activists in its network. Similarly, the Drug Policy Foundation's website claims "23,000 supporters." And, we believe that there is substantial overlap between groups such as these, as well as other "reform" groups.

Study after study confirms the concerns of Americans about drugs, and their desire to guard against the risks of these deadly substances. A 1998 poll of voters conducted by the Family Research Council found that eight of ten respondents rejected the legalization of drugs like cocaine and heroin, with seven out of ten in strong opposition. Moreover, when asked if they supported making these drugs legal in the same way that alcohol is, 82 percent said they opposed legalization. Similarly, a 1999 Gallup poll found that 69 percent of Americans oppose the legalization of marijuana.[19] A recent study by the Chicago Council on Foreign Affairs found that the American public consider drug abuse the third biggest problem facing our country today.[20]

Not only do Americans reject legalization, they also support policies to rid their communities, schools, and workplaces of drugs. For example, a 1995 Gallup poll found that 72 percent of Americans want drug testing in the workplace.[21] Sixty-seven percent supported random drug testing by employers.[22] This same survey found that 73 percent of all American employees support their employers drug-free workplace policies and programs. Another 23 percent of American employees want their employers to go even further and adopt tougher programs. Similarly, a soon-to-be released Gallup poll finds that 85 percent of Americans support greater funding for drug interdiction.[23]

One of the best measures of the public's rejection of drugs is the number of Americans -- fifty-million -- who have used drugs during their younger years, but now reject them. Even among individuals who themselves tried drugs, 73 percent believe that parents should forbid children from ever using any drug at any time.[24]

The American public's opinion about illegal drugs is clear: they want no part of them. Americans don't want their children, friends or family members doing drugs. They don't want drugs in their workplace. They don't want to live in fear that their pilot or bus driver is on drugs. And, they support efforts, ranging from education to treatment to law enforcement, to combat drug use.

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[19]Gallup Organization, Americans Oppose General Legalization of Marijuana (1999).

[20]*See* John E. Reilly, *Americans and the World: A Survey at the Century's End,* 114 Foreign Policy 97, 110 (1999).

[21]Gallup Organization, What American Employees Think About Drugs (1995) (prepared for the Institute for a Drug-Free Workplace).

[22]*Id.*

[23]Gallup, soon to be released poll, prepared for ONDCP (1999).

[24]Partnership for a Drug Free America, Parents and Marijuana in the 90s, Partnership Attitude Tracking Study (1997).

FALLACY: Drug legalization will not increase drug use.

REALITY: DRUG LEGALIZATION WOULD SIGNIFICANTLY INCREASE THE HUMAN AND ECONOMIC COSTS ASSOCIATED WITH DRUGS.

Proponents argue that legalization is a cure-all for our nation's drug problem. However, the facts show that legalization is not a panacea but a poison. In reality, legalization would dramatically expand America's drug dependence, significantly increase the social costs of drug abuse, and put countless more innocent lives at risk.

A. "The Dutch Model"

Those who support legalization often hold up the Netherlands as an example that legalization can work. While the Dutch have adopted a "softer" approach to some drugs, they have not legalized them. Under the Dutch system possession and small sales of marijuana have been decriminalized. However, marijuana production and larger scale sales remain criminal. Drugs such as cocaine and heroin remain illegal. Most importantly, while the Dutch have not legalized drugs, the softening of Dutch criminal laws against marijuana has led to a normalization of drug use more broadly. The accompanying change in public attitudes has, arguably, played as critical a role in Dutch drug use patterns as has the shift in the actual law.

If the Dutch experience with drugs is an appropriate model at all, it is because it illustrates the harms that result from increased tolerance of illegal drugs. This conclusion was brought home to all of us from the Office of National Drug Control Policy who traveled to the Netherlands in July of 1998 to gain a better understanding of the Dutch approach.[25]

When the so-called Dutch "coffee shops," started selling marijuana in small quantities, use of the drug more than doubled between 1984 and 1996 among 18 to 25 year olds.[26] According to an article, *Holland's Half-Baked Drug Experiment*, which appears in the current (May/June 1999) edition of *Foreign Affairs:* "In 1997, there was a 25 percent increase in the number of registered

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[25]*See* Director Barry R. McCaffrey, Memorandum for the President's Drug Policy Council, *ONDCP Trip to Europe (11-18 July 1998)*, September 2, 1998.

[26]Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 Foreign Affairs 82, 88 (May/June 1999); *see also* Robert Dupont, Eric Voth, *Drug Legalization, Harm Reduction, and Drug Policy,* 123 Annals of Internal Medicine 461-465 (1995) (citing a 30 percent increase in the number of Dutch marijuana addicts from 1991 to 1993 alone).

cannabis addicts receiving treatment, as compared to a mere 3 percent rise in cases of alcohol abuse."[27]

Moreover, Dutch tolerance of drug use has created a climate that drug manufacturers and traffickers have seized upon to produce and market more addictive and dangerous drugs. For example, Peter Reijnders, Assistant Chief Constable and Chief of the Dutch National Unit on Synthetic Drugs, recently told the 25th European Meeting of Heads of National Drug Services, that: " . . .[T]he Netherlands is a major country as far as it concerns involvement in the production of illicit synthetic drugs."[28]

Dutch drug manufacturers are also producing a new form of marijuana, *Nederwiet,* with THC contents as high as 35 percent -- as much as ten times the THC of the cannabis available just a few years ago. Cannabis seeds can even be ordered over the Internet from an Amsterdam-based dealer.[29] The well-respected journal *Foreign Affairs* describes the situation as follows:

> . . . [T]he annual Nederwiet harvest is a staggering 100 tons a year, almost all grown illegally. And it does not stay in the Netherlands. Perhaps as much as 65 tons of pot is exported -- equally illegally -- to Holland's neighbors. Holland now rivals Morocco as the principal source of European marijuana. By the Dutch Ministry of Justice's own estimates, the Nederwiet industry now employs 20,000 people. The overall commercial value of the industry, including not only the growth and sale of the plant itself but the export of high-potency Nederwiet seeds to the rest of Europe and the United States, is 20 billion Dutch guilders, or about $10 billion -- virtually all of it illegal and almost none of it subject to any form of Dutch taxation. The illegal export of cannabis today brings in far more money than that other traditional Dutch crop, tulips.[30]

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[27]Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 Foreign Affairs 82, 88 (May/June 1999).

[28]*See* Lecture by Peter Reijnders, llc., Assistant Chief Constable, Chief of the National Unit Synthetic Drugs of the Netherlands, delivered at the 25th European Meeting of Heads of National Drug Services, Edinburgh, UK, May 4-6, 1999.

[29]*See* "www.aloha.nl".

[30]Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 Foreign Affairs 82, 89 (May/June 1999); *see also* Director Barry R. McCaffrey, Memorandum for the President's Drug Policy Council, *ONDCP Trip to Europe (11-18 July 1998)*, September 2, 1998.

The impact of high potency marijuana on Dutch youth has been severe. In *Foreign Affairs*, Dr. Ernest Bunning of the Ministry of Health, is quoted as saying:

> There are young people who abuse soft drugs . . . particularly those that have high THC. The place that cannabis takes in their lives becomes so dominant they don't have space for other important things in life. They crawl out of bed in the morning, grab a joint, don't work, smoke another joint. They don't know what to do with their lives. I don't want to call it a drug problem because if I do, then we have to get into a discussion that cannabis is dangerous, that sometimes you can't use it without doing damage to your health or your psyche. The moment we say, "There are people who have problems with soft drugs," our critics will jump on us, so it makes it a little bit difficult for us to be objective on this matter.[31]

During this period of tolerance, the Netherlands has also experienced a serious problem with other substances of abuse, in particular heroin and synthetic drugs, which remain illegal. According to a 1998 report from the European Monitoring Centre for Drugs and Drug Addiction, the number of heroin addicts in Holland has almost tripled since the liberalization of drug policies.[32] Similarly, the 1998 European Monitoring Centre for Drugs and Drug Addiction's overview report states that drug-related arrests in the Netherlands were up over 40 percent in the last three years, with the main offense being trafficking in so called hard drugs.[33]Increasingly this problem is spilling over to other nations.[34] The Netherlands is more and more seen as Europe's

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[31]*Id.* at p. 87. In this same article, Dr. Wallenberg, head of the Jellinek Clinic, Holland's best known drug clinic, stated: "We have indulged ourselves in a kind of blind optimism in Holland concerning cannabis." *Id.* This apparent inability to critically examine the impacts of quasi-legalized drug policies on drug use trends has substantially aided those in the United States who want to legalize drugs. Absent a full assessment of the increasing drug use trends, proponents of legalization are free to say whatever they like about the success of the model.

[32] *See* European Monitoring Centre for Drugs and Drug Addiction, Study to Obtain Comparable National Estimates of Problem Drug Use, Dec. 1998 (finding 28,000 Dutch heroin addicts in 1997, up from 10,000 in 1979); Larry Collins, *Holland's Half-Baked Drug Experiment,* 78 Foreign Affairs 82, 92 (1999) (citing Dutch government funded Trimbos Institute data indicating a tripling of the rate of heroin addiction); *see also* Robert Dupont, Eric Voth, *Drug Legalization, Harm Reduction, and Drug Policy,* 123 Annals of Internal Medicine 461-465 (1995) (citing a 22 percent increase in the number of registered addicts between 1988 and 1993).

[33]The European Monitoring Centre for Drugs and Drug Addiction, Annual Report on the State of the Drugs Problem in Europe, 31 (1998). The Netherlands was the only nation among fifteen EU member states listed with trafficking of hard drugs as the main offense driving these increases in drug-related arrests. *Id.*

synthetic drug production center by law enforcement agencies. It is reported that British Customs has determined that virtually all the synthetic drugs seized in the United Kingdom last year were manufactured in the Netherlands or Belgium.[35] Similar reports suggest that 98 percent of the amphetamines seized in France in 1997 came from Holland, as did 73.6 percent of the ecstasy tablets.[36] Synthetic drugs manufactured in the Netherlands are also now increasingly turning up in the United States.[37]

These impacts are not lost upon the Dutch people who increasingly support a more balanced approach to fighting drug use. A 1995 poll by Telepanel, a polling organization associated with the University of Amsterdam found that nearly three-quarters of the Dutch people want tougher measures against those who deal in *and* use drugs.[38] Despite the normalization of marijuana in the Netherlands over half the Dutch people believe "soft drugs" should be criminalized.[39] By way of comparison, these numbers are far higher than the support for alternative drug policies in the United States.[40]

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[34]*See* Lecture by Peter Reijnders, llc., Assistant Chief Constable, Chief of the National Unit Synthetic Drugs of the Netherlands, delivered at the 25th European Meeting of Heads of National Drug Services, Edinburgh, UK, May 4-6, 1999 (noting that 26 different countries worldwide have reported seizures of MDMA originating in the Netherlands, including 124 cases involving more than 500 grams).

[35]Larry Collins, *Holland's Half-Baked Drug Experiment,* 78 Foreign Affairs 82, 84 (1999).

[36]*Id.*

[37]*Id.* at 97.

[38]Hassela Nordic Network, Press Release, Nov. 9, 1995.

[39]Hassela Nordic Network, Press Release, June 14, 1995 (poll by the newspaper *Algemeen Dagblad*); Hassela Nordic Network, Press Release, Nov. 9, 1995 (poll by Erasmus University, Rotterdam, finding 61 percent of Dutch think all drugs should be prohibited).

[40]*See, e.g.,* Gallup Organization, Americans Oppose General Legalization of Marijuana (1999).

Proponents of legalization argue that the Dutch experience provides a model for a "softer approach" to fighting drug use. Upon close examination the pitfalls of the Dutch experience offer more than ample evidence to dissuade the United States from adopting the drug policies of the Netherlands.[41] Instead the Dutch example clearly argues in favor of continuing the balanced U.S. approach, which is producing results.

B. The American Experience

American experiences with drug legalization portend similar risks to those experienced in Holland. During the 1970s, our nation engaged in a serious debate over the shape of our drug control policies. (For example, within the context of this debate, between 1973 and 1979, eleven states "decriminalized" marijuana). During this timeframe, the number of Americans supporting marijuana legalization hit a modern-day high.[42] While it is difficult to show causal links, it is clear that during this same period, from 1972 to 1979, marijuana use rose from 14 percent to 31 percent among adolescents, 48 percent to 68 percent among young adults, and 7 percent to 20 percent among adults over twenty-six.[43] This period marked one of the largest drug use escalations in American history.

A similar dynamic played out nationally in the late 1800's and early 1900's. Until the 1890s, today's controlled substances -- such as marijuana, opium, and cocaine -- were almost completely unregulated.[44] It was not until the last decades of the 1800s that several states passed

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[41]The experiences of other nations that have flirted with legalization-like schemes also provide evidence that legalization is not a viable policy option. For example, in 1964, Great Britain began providing medical prescriptions for heroin to addicts. The policy was discontinued because it caused a 100 percent increase in the numbers of addicts and contributed to a significant increase in crime.

See Drug Enforcement Administration, Drug Legalization: Myths and Misconceptions, 17 (1994). Similarly, during ONDCP's 1998 trip to Sweden, Swedish officials described how that nation had tried and rejected a more liberalized approach to drug control because use rates and attendant harms had increased significantly with the liberalization.

[42]*See* Bureau of Justice Statistics, Sourcebook of Criminal Justice Statistics 1997, 150-151 (1997). In 1973, 18 percent of the American people supported legalization of marijuana. In 19976, that number grew to 28 percent. By 1978, that number reached 30 percent, the highest it has reached from the 1970's to date.

[43]*See* ADAMHA, PHS, DHHS, *National Household Survey on Drug Abuse: Main Findings 1985* (1988).

[44]*See* David Musto, The American Disease, 10 (1972).

narcotics control laws.[45] Federal regulation of narcotics did not come into play until the Harrison Act of 1914.

Prior to the enactment of these laws, narcotics were legal and widely available across the United States. In fact, narcotics use and its impacts were commonplace in American society. Cocaine was found not only in early Coca-Cola (until 1903) but also in wine, cigarettes, liqueur-like alcohols, hypodermic needles, ointments, and sprays. Cocaine was falsely marketed as a cure for hay fever, sinusitis and even opium and alcohol abuse. Opium abuse was also widespread. One year before Bayer introduced aspirin to the market, the company also began marketing heroin as a "nonaddictive," no prescription necessary, over-the-counter cure-all.

During this period, drug use and addiction increased sharply. While there are no comprehensive studies of drug abuse for this period that are on par with our current *National Household Survey on Drug Abuse* and *Monitoring the Future* studies, we can, for example, extrapolate increases in opium use from opium imports, which were tracked.[46] Yale University's Dr. David Musto, one of the leading experts on the patterns of drug use in the United States, writes: "The numbers of those overusing opiates must have increased during the nineteenth century as the per capita importation of crude opium increased from less than 12 grains annually in the 1840s to more than 52 grains in the 1890s."[47] Only in the 1890s when societal concerns over and disapproval of drug use began to become widespread and triggered legal responses did these rates level off.[48] Until this change in attitudes began to denormalize drug use, the United States experienced over a 400 percent increase in opium use alone. This jump is even more staggering if one considers that during this period other serious drugs, such as cocaine, were also widely available in every-day products.

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[45]*Id.* at p. 10, 91-95. Pennsylvania passed the first state-level anti-morphine law as early as 1860. *Id.* at p. 91. Ohio followed suit with an anti-opium smoking law in 1897. *Id.*

[46]During this period almost all U.S. opium was imported for domestic use with little or no transhipment. Thus, for this timeframe rates of imports are the best indicator for rates of domestic use. *Id.* at p. 252, note 5.

[47]*Id.* at p. 5. Domestic demand for opium began to increase in the 1840s and continued to grow until roughly the 1890s. At its peak in the 1890s domestic consumption of crude opium leveled off at a high of 500,000 pounds each year. At the same time, morphine and morphine salts consumption reached 20,000 ounces annually. *Id.* at p. 252, note 5.

[48]*Id.* at p. 252, note 5, and accompanying text.

Moreover, while we do not believe that the period of prohibition on alcohol is directly analogous to current efforts against drugs,[49] our experiences with alcohol prohibition also raise parallel concerns. While prohibition was not without its flaws, during this period alcohol usage fell to between 30 to 50 percent of its pre-prohibition levels.[50] From 1916 to 1919 (just prior to prohibition went into effect in 1920), U.S. alcohol consumption averaged 1.96 gallons per person per year.[51] During prohibition, alcohol use fell to a low of .90 gallons per person per year.[52] In the decade that followed prohibition's repeal, alcohol use increased to a per capita annual average of 1.54 gallons and has since steadily risen to 2.43 gallons in 1989.[53] Prohibition also substantially reduced the rates of alcohol-related illnesses.[54]

The United States has tried drug legalization and rejected it several times now because of the suffering it brings. The philosopher Santayana was right in his admonition that "those who cannot remember the past are condemned to repeat it." Let us not now be so foolish as to once again consider this well worn, dead-end path.

C. The Impact on Youth

Most importantly the legalization of drugs in the United States would lead to a disproportionate increase in drug use among young people. In 1975, the Alaskan Supreme Court invalidated certain sections of the state's criminal code pertaining to the possession of marijuana. Based on this finding, from 1975 to 1991, possession of up to four ounces of the drug by an adult who was

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[49]Most importantly, prohibition sought to stop a societal behavior that was socially accepted and widespread. In contrast, our current drug policies are backed by overwhelming societal disapproval of drugs. *See* Robert Dupont, Eric Voth, *Drug Legalization, Harm Reduction, and Drug Policy,* 123 Annals of Internal Medicine 461-465 (1995).

[50]Paul Aaron and David Musto, *Temperance and Prohibition in America: A Historical Overview,* in Beyond the Shadow of Prohibition, 164-165 (Mark H. Moore & Dean P. Gerstein eds., 1981).

[51]Arnold Trebach & James Inciardi, Legalize It? Debating American Drug Policy, 109-110 (1993).

[52]*Id.*

[53]*Id.*

[54]*See* Mark H. Moore, *Actually, Prohibition Was a Success,* New York Times, A21, Oct. 16, 1989. During prohibition, cirrhosis death rates for men went from 29.5 per 100,000 in 1911, to 10.7 per 100,000 in 1929. Admissions to state mental hospitals for alcohol psychosis also fell from 10.1 per 100,000 in 1919 to 4.7 per 100,000 in 1928. *Id.; see also* John Noble, *et al., Cirrhosis Hospitalization and Mortality Trends 1970-87,* 108 Public Health Reports 192 (1993).

lawfully in the state of Alaska became legal.[55] Even though marijuana remained illegal for children, marijuana use rates among Alaskan youth increased significantly.[56] In response, concerned Alaskans, in particular the National Federation of Parents for Drug-Free Youth, sponsored an anti-drug referendum that was approved by the voters in 1990, once again rendering marijuana illegal.

In addition to the impact of expanded availability, legalization would have a devastating effect on how our children see drug use. Youth drug use is driven by attitudes. When young people perceive drugs as risky and socially unacceptable youth drug use drops. Conversely, when children perceive less risk and greater acceptability in using drugs, their use increases. If nothing else, legalization would send a strong message that taking drugs is a safe and socially accepted behavior that is to be tolerated among our peers, loved ones and children. Such a normalization would play a major role in softening youth attitudes and, ultimately, increasing drug use.

The significant increases in youth drug use that would accompany legalization are particularly troubling because their effects would be felt over the course of a generation or longer. Without help, addictions last a lifetime. Every additional young person we allow to become addicted to drugs will impose tremendous human and fiscal burdens on our society. Legalization would be a usurious debt upon our society's future -- the costs of such an approach would mount exponentially with each new addict, and over each new day.

D. The Impact of Drug Prices

If drugs were to be legalized, we could also expect that the attendant drop in drug prices to cause drug use rates to grow as drugs become increasingly affordable to buy.[57] Currently a gram of cocaine sells for between $150 and $200 on U.S. streets.[58] The cost of cocaine production is as

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[55]*See* Rain v. Stark, 537 P.2d 494 (AK 1975). The court's holding did not effect the statutory provisions dealing with the purchase, sale or manufacture of marijuana, which remained illegal during this period.

[56]Information provided by Drug Watch International (citing Bernard Segal, Center for Alcohol and Addiction Studies University of Alaska, *Drug Taking Behavior Among Alaskan Youth -- 1988*, Nov. 1988).

[57]*See* Grossman *et al.*, *Rational Addiction and the Effect of Price on Consumption,* in Searching for Alternatives, at p. 77 (Melvyn B. Kraus & Edward P. Lear, eds. 1991) (with respect to cigarettes a 10 percent drop in price yields a 7 to 8 percent increase in demand).

[58]ABT Associates, *The Price of Illicit Drugs: 1981 Through Second Quarter of 1998*, prepared for ONDCP (Feb. 1999).

low as $3 per gram.[59] In order to justify legalization, the market cost for legalized cocaine would have to be set so low as to make the black market, or bootleg cocaine, economically unappealing.[60]

Assume, for argument sake, that the market price was set at $10 per gram, a three hundred percent plus markup over cost, each of the fifty hits of cocaine in that gram could retail for as little as ten cents.

With the cost of "getting high" so as low as a dime (ten cents) -- about the cost of a cigarette -- the price of admission to drug use would be no obstacle to anyone even considering it.[61] However, each of these "dime" users risks a life-long drug dependence problem that will cost them, their families, and our society tens of thousands of dollars.

In addition to the impact on youth, we would also expect to see falling drug prices drive increasing drug use among the less affluent. Among these individuals the price of drug use -- even at today's levels -- remains a barrier to entry into use and addiction. The impact of growing use within these populations could be severe. Many of these communities are already suffering the harms of drug use -- children who see no other future turning to drugs as an escape, drug dealers driving what remains of legitimate business out of their communities, and families being shattered by a loved one hooked on drugs. Increased drug use would set back years of individual, local, state and federal efforts to sweep these areas clean of drugs and build new opportunities.

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[59]Moreover, the cost of production of legalized cocaine would shrink below today's levels. For example, the shipment of legal cocaine without the need to conceal, the movement of profits without the need to launder, and the ability to manufacture without and market without losses to law enforcement, would all provide significant economies.

[60]*See* George Soros, Soros on Soros, 200 (1995) (recognizing the need to set prices of legalized drugs low enough to undercut a black market).

[61]The impact of pricing on youth substance use is well established with respect to alcohol and taxes. Moreover, one study has found that increases in alcohol prices not only reduces youth alcohol consumption, but also marijuana use. *See* Rosalie Liccardo Pacula, *Does Increasing the Beer Tax Reduce Marijuana Consumption?,* 17 J. Health Economics 557-585 (1998).

FALLACY: Drug legalization would reduce the harm of drug use on our society.

REALITY: DRUG LEGALIZATION WOULD COST BILLIONS OF DOLLARS AND RISK MILLIONS OF ADDITIONAL INNOCENT LIVES.

By increasing the rates of drug abuse, legalization would exact a tremendous cost on our society. If drugs were legalized, the United States would see significant increases in the number of drug users, the number of drug addicts, and the number of people dying from drug-related causes. While many of these costs would fall first and foremost on the user, countless other people would also suffer if drugs were legalized. Contrary to what libertarians and legalizers would have us believe, drug use is not a victimless crime.

A. Increases in Child Abuse and Neglect

Innocent children suffer the most from drug abuse. In *No Safe Havens*, experts from Columbia University's Center for Addiction and Substance Abuse found that substance abuse (including drugs and alcohol) exacerbates seven of every ten child abuse or neglect cases.[62] In the last ten years, driven by substance abuse, the number of abused and neglected children has more than doubled, up from 1.4 million in 1986 to three million in 1997.[63] In 1994, *the American Journal of Public Health* reported that children whose parents abuse drugs or alcohol are four times more likely to be neglected and/or abused than children with parents who were not drug abusing.[64] If drugs were made legal, among the growing ranks of the addicted will be scores of people with children. Given the clear linkage between rates of addiction and child abuse and neglect, more drug use will cause tens of thousands of additional children to suffer from abuse and neglect as parents turn away from their children to chase their habit.

B. Increases in Drugged Driving Accidents

Over the last ten years, Americans have grown increasingly aware of the death toll related to drinking and driving. While we focus less on the risks of drugged-driving, the fact is that if the driver on the road next to you is drugged, you and whoever is riding with you are at risk. A National Transportation Safety Board study of 182 fatal truck accidents revealed that 12.5 percent of the drivers had used marijuana, in comparison to 12.5 percent who used alcohol, 8.5

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[62]Jeanne Reid, *et al., No Safe Haven: Children of Substance Abusing Parents* (1990) (published by the National Center on Addiction and Substance Abuse at Columbia University).

[63]*Id.*

[64]Chaffin M. Kellecherk, Fischer E. Hollenberg, *Alcohol and Drug Disorders Among Physically Abusive and Neglectful Parents in a Community-Based Sample,* 84 Am. J. Public Health 1586-90 (1994).

percent who used cocaine and 7.9 percent who used stimulants.[65] Illegal drugs (marijuana, cocaine, and stimulants combined) were present in more accidents than alcohol -- even though alcohol is legal and far more available. "A study of 440 drivers, ages 15 to 34 years old, who

were killed in California during a two-year period detected alcohol and marijuana in one-third of victims. More than one-half consumed a drug or drugs other than alcohol."[66]

Historically, we believe that impaired drivers drive more recklessly. A 1995 roadside study conducted in Memphis, Tennessee of reckless drivers not believed to be impaired by alcohol, found that 45 percent tested positive for marijuana.[67]

Most disturbingly, drugged driving often appears among the most inexperienced drivers, namely young people. The *1996 National Household Survey on Drug Abuse* found that 13 percent of young people aged sixteen to twenty drove a car less than two hours after drug use at least once during the past year.[68] These young drivers are generally unaware of the dangers they present to themselves and others. Among 16 to 20 year olds who drove after marijuana use, 57 percent said they did so because they were not "high enough to cause a crash."[69]

When a person using drugs takes the wheel, his drug use is likely to have human costs. Not only is the drugged driver at risk, but all those around him are as well. On January 29, 1999, a car with five young girls -- high school juniors in a middle class suburb of Philadelphia -- crashed into a tree, killing the driver and the other occupants.[70] The medical examiner's report concluded

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[65]National Transportation Safety Board Report, Washington, D.C., February 5, 1990.

[66]NHTSA, The Highway Safety Deskbook, Part IV (1996).

[67]Brookoff, D. *et al., Testing Reckless Drivers for Cocaine and Marijuana,* 320 New Eng. J. Med. 762-768 (1994).

[68]Office of Applied Statistics, *Driving After Drugs or Alcohol Use: Findings From the 1996 National Household Survey on Drug Abuse* (1998) (published by NHTSA, DOT, SAMSHA and HHS). Findings with respect to youth drinking and driving also suggest that if drugs were made legal, drugged driving would be most problematic among young people. *See, e.g.,* National Highway Traffic Safety Administration, Alcohol Traffic Safety Facts 1997, 1997 (the highest intoxication rates in fatal crashes in 1997 were recorded for drivers 21-24 years old).

[69]Office of Applied Statistics, *Driving After Drugs or Alcohol Use: Findings From the 1996 National Household Survey on Drug Abuse* (1998) (published by NHTSA, DOT, SAMSHA and HHS).

[70]*See, e.g.,* CNN The World Today, *Deaths of Five Schoolgirls in Philadelphia Car Crash Raises Awareness of Chemical Inhalants,* Mar. 2, 1999, 8:24 pm EST (LEXIS/NEXIS).

that the driver lost control of the car not because of speed or inexperience but because she was impaired from "huffing" -- inhaling a chemical solvent -- to get high. Three of the passengers were also found to have used the drug. Five more young people, all with bright futures, are dead because of drug use behind the wheel.

If drugs were legalized the rate of drugged driving would increase. Added to the countless tragedies caused by drinking and driving would be scores of deaths and injuries from people taking legalized drugs and driving while impaired.

According to the National Highway Traffic Safety Administration (NHTSA), there were 16,189 alcohol-related traffic fatalities in 1997 (38.6 percent of the total traffic fatalities for the year).[71] NHTSA also reports that in 1997, more than 327,000 people were injured in auto crashes where police reported that alcohol was present.[72] These tragic statistics make abundantly clear the risks we would face if other drugs, such as heroin, marijuana and LSD, were made legal and widely available.

C. Increases in Workplace Accidents, Decreasing Productivity

Just as drug impairment behind the wheel puts others at risk, so too does impairment on the job. Since over 60 percent of drug users in the United States are employed,[73] it is not surprising that workplace drug use is a significant problem. According to a 1995 Gallup survey, 35 percent of American employees report having seen drug use on-the-job by co-workers.[74] One-in-ten report having been offered drugs while at work.[75] Drug use in the workplace diminishes productivity and increases costs.[76] Drug using employees are more likely to have taken an unexcused absence in the last month, and are more likely to change or leave a job.[77] The National Institute on Drug

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[71]National Highway Traffic Safety Administration, Alcohol Traffic Safety Facts 1997, 1997.

[72]*Id.*

[73]Office of Applied Studies, SAMSHA, *National Household Survey on Drug Abuse: Main Findings 1997* (1998).

[74]Gallup Organization, What American Employees Think About Drugs (1995) (prepared for the Institute for a Drug-Free Workplace).

[75]*Id.*

[76]*See, e.g.,* Robert Dupont, *Never Trust Anyone Under 40: What Employers Should Know About Drug Testing* 48 Policy Review pp. 52-57 (1989) (drug using workers are 3 to 4 times as likely to have an on-the-job accident, 2 to 3 times as likely to file a medical claim, and 25 to 35 percent less productive).

Abuse and the National Institute on Alcohol Abuse and Alcoholism estimated that the cost to our nation's productivity from illegal drug use was $69.4 billion in 1992.[78] Increasing rates of drug use burden our economy as a whole. They also place businesses, in particular small businesses, at risk. In the end, it is the American consumer who ultimately pays these costs.

When drugs are mixed with the heavy machinery of industry, the results can be devastating. In 1987, a Conrail freight train operated by an engineer who had been smoking marijuana struck an Amtrak passenger train, killing sixteen people and injuring more than one-hundred.[79] Last July, a passenger train and a truck carrying steel coils collided.[80] The driver of the truck, who was cited by police for more than a dozen violations relating to the crash, tested positive for marijuana immediately following the accident. The collision dislodged one of the twenty-ton coils, causing it to roll through the train's first passenger compartment, killing three and injuring others.[81] Highly publicized disasters like these capture the public's attention. However, the harms of drug abuse build incrementally on job sites all across the nation, every day. Utah Power & Light employees who tested positive on pre-employment drug tests were five times more likely to be involved in a workplace accident than those who tested negative.[82] The 1995 Gallup survey similarly found that 42 percent of American employees believe that drug use greatly affects

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[77]ONDCP, *The 1999 National Drug Control Strategy,* 17 (1999).

[78]The National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, *The Economic Costs of Alcohol and Drug Abuse in the United States, 1992,* 5-1 (1998).

[79]*See, e.g.,* CNN NEWS, *A Historical Perspective on Amtrak Accidents,* Sept. 22, 1993; Lori Sharn, *Will Tests Keep Booze Out of Cabs, Cockpits,* USA Today, Jan. 14, 1992, 1A; Rep. Bob Whittaker, *The Drugs and Alcohol Crisis; Congress Must Pass Legislation Requiring Workers to Take Drug and Alcohol Tests Before Assuming Life Threatening Responsibilities,* Roll Call, July 23, 1990, Briefing No. 17.

[80]*See, e.g.,* Jon Hilkevich, *Police Say Test Shows Drug Use By Trucker in Train Crash,* Chicago Tribune, June 25, 1998, 1; *Marijuana Found in Trucker Involved in Fatal Train Wreck,* New York Times, June 25, 1998, A16.

[81]*See supra* n. 80.

[82]*See* Testimony of Mark A. DiBernardo, Executive Director, Institute for a Drug-Free Workplace, Before the House Committee on Government Reform and Oversight, Subcommittee on National Security, International Affairs and Criminal Justice, on Employer Drug-Testing and Drug Abuse Prevention, June 27, 1996.

workplace safety.[83] Even these numbers are likely to underestimate the harms caused by drugs on-the-job; for a variety of reasons drug-related on-the-job injuries are likely under-reported.

One way to factor the risks presented by on-the-job drug use is to extrapolate from the rate at which drug-free workplace programs can reduce job-related accidents. For example, the Boeing corporation's drug-free workplace program has saved over $2 million in employee medical claims.[84] At Southern Pacific railroad, the injury rate dropped 71 percent with the development of a drug-free workplace assistance program.[85] One of the major auto manufacturers has reported 82 percent decline in job-related accidents since implementing an employee substance abuse assistance program. Similarly, an Ohio study found that substance abuse treatment programs significantly reduced on-the-job injuries.[86] If job-related drug assistance programs can prevent such high rates of accidents, it follows that drugs cause large numbers of injuries among America's employees.

If drugs were made legal, use -- including on-the-job drug use -- will increase. Growing numbers of drug users operating heavy equipment, driving tractor-trailers, and operating buses, would inevitably lead to greater numbers of workplace injuries. While the impaired drug user is most at risk from their own actions, countless innocent people -- co-workers and ordinary citizens -- would also face added dangers. Additionally, apart from the human costs, significantly increased numbers of on-the-job drug-related accidents would cost the American economy countless millions -- ranging from rising insurance costs, to personal injury settlements, to losses through decreased productivity.

FALLACY: Drugs are harmful because they are illegal.

REALITY: DRUGS ARE HARMFUL NOT BECAUSE THEY ARE ILLEGAL; THEY ARE ILLEGAL BECAUSE THEY ARE HARMFUL.

Critics argue that the harm to our society from drugs, such as the costs of crime, could be reduced if drugs were legalized. The logic is flawed. By increasing the availability of drugs, legalization would dramatically increase the harm to innocent people. With more drugs and drug

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[83]The Gallup Organization, What American Employees Think About Drugs (1995) (prepared for the Institute for a Drug-Free Workplace).

[84]Dan Rhodes, *Drugs in the Workplace,* 67 Occupational Health & Safety 136-138 (1998).

[85]*Id.*

[86]*Id.* (The Ohio study found that substance abuse treatment programs could reduce on-the-job injuries by as much as 97).

use in our society, there would be more drug-related child abuse, more drugged driving fatalities, and more drug-related workplace accidents. None of these harms are caused by law or law enforcement but by illegal drugs.

Even with respect to the crime-related impact of drugs, drug-related crimes are driven far more by addiction than by the illegality of drugs. Law enforcement doesn't cause people to steal to support their habits; they steal because they need money to fuel an addiction -- a drug habit that often precludes them from earning an honest living. Even if drugs were legal, people would still steal and prostitute themselves to pay for addictive drugs and support their addicted lifestyles. Dealers don't deal to children because the law makes it illegal; dealers deal to kids to build their market by hooking them on a life-long habit at an early age, when drugs can be marketed as cool and appealing to young people who have not matured enough to consider the real risks. Make no mistake: legalizing drugs won't stop pushers from selling heroin and other drugs to kids. Legalization will, however, increase drug availability and normalize drug-taking behavior, which will increase the rates of youth drug abuse.

For example, although the Dutch have adopted a more tolerant approach to illegal drugs, crime is in many cases increasing rapidly in Holland. The most recent international police data (1995) shows that Dutch per capita rates for breaking and entering, a crime closely associated with drug abuse, are three times the rate of those in Switzerland and the United States, four times the French rate, and 50 percent greater than the German rate.[87] "A 1997 report on hard-drug use in the Netherlands by the government-financed Trimbos Institute acknowledged that 'drug use is considered the primary motivation behind crimes against property' -- 23 years after the Dutch [drug] policy was supposed to put a brake on that."[88] Moreover, *Foreign Affairs* recently noted that in areas of Holland where youth cannabis smokers are most prevalent, such as Amsterdam, Utrecht and Rotterdam, the rates of juvenile crime have "witnessed skyrocketing growth" over the last three to four years.[89] Statistics from the Dutch Central Bureau of Statistics indicate that between 1978 and 1992, there was a gradual, steady increase in violence of more than 160 percent.[90]

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[87]*See* Interpol, International Crime Statistics (1995); *see also* Director Barry R. McCaffrey, Memorandum for the President's Drug Policy Council, *ONDCP Trip to Europe (11-18 July 1998)*, September 2, 1998.

[88]Larry Collins, *Holland's Half-Baked Drug Experiment*, 78 Foreign Affairs 82, 92 (1999).

[89]*Id.* at 88.

[90]P. Van Kalleveen, Violent Crimes in Central Bureau of Statistics, Justitiele Verkenningen (1), 29-47 (1994).

In contrast, crime rates in the United States are rapidly dropping. For example, the rate of drug-related murders in the United States has hit a ten-year low.[91] In 1989, there were 1,402 drug-related murders. By 1997 that number fell to 786. In 1995, there were 581,000 robberies in the United States. By 1997, that number fell to roughly 498,000.[92]

America's criminal justice system is not the root cause of drug-related crime. It is the producers, traffickers, pushers, gangs and enforcers who are to blame, as are all the people who use drugs and never think about the web of criminality and suffering their drug money supports.

FALLACY: We are fighting a war on drugs.

REALITY: OUR BALANCED EFFORTS AGAINST DRUGS ARE ANALOGOUS TO THE FIGHT AGAINST CANCER.

Wars have defined end states -- victory over an enemy. Our efforts against drugs have no such neatly defined end; with each generation the struggle to prevent drug use begins anew. Addicted Americans -- parents, siblings, and children -- are not the enemy, they require treatment. Wars are waged with weapons and soldiers; prevention and treatment are our primary tools against drugs. Consequently, our efforts to reduce drug use are analogous to the fight against cancer.

Nevertheless, an effective counter-drug strategy must focus on both supply and demand reduction. Supply-side efforts (law enforcement and interdiction) are necessary because, as basic economic rules dictate, unabated supply will ultimately create its own demand. However, those of us who have experienced combat know that such supply-side efforts are a far cry from "war." In fact, the use of civilian authorities to protect against drugs is no more war-like than the same role these same police officers play in combating robberies, car thefts, or domestic violence. It is sheer folly to suggest that when a police officer patrols a neighborhood to stop these other crimes he is doing a community service, however when he finds drugs, his efforts somehow become part of a conjured up "drug war."

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[91]Federal Bureau of Investigation, Uniform Crime Report for the United States (1997).

[92]*Id.*

FALLACY: Our current approach to drugs is not making a difference.

REALITY: WE ARE MAKING STRONG, STEADY PROGRESS IN REDUCING DRUG USE AND PREVENTING YOUNG PEOPLE FROM TURNING TO DRUGS.

Rather than trade rhetoric, we should focus on results:

- Over the last twenty years we have cut drug use (past month) in the United States by half and reduced cocaine use by 75 percent (past month).[93]

- Over the last two years, youth drug use rates have leveled off and in many cases have begun to fall. This shift marks a sharp departure from the prior six years, which saw steady increases in youth drug use. Most importantly, we have begun to see a sharpening of youth attitudes against drugs -- youth increasingly see drugs as risky and unacceptable.[94]

- The number of drug-related murders has now hit a ten-year low. In 1989, there were 1402 drug-related murders; by 1997 that number had fallen to 786.[95]

- Spending on illegal drugs has dropped 37 percent from 1988 to 1995, an annual savings of $34.1 billion.[96]

Such results against any other societal ill would be called a huge success. Only the combined, bipartisan efforts of the Congress and the full Executive branch have made such progress possible.

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[93]Office of Applied Statistics, SAMSHA, *National Household Survey on Drug Abuse: Main Findings 1997* (1998).

[94]*Id.*

[95]Federal Bureau of Investigation, Uniform Crime Report for the United States (1997).

[96]ONDCP, What America's Users Spend on Illegal Drugs, 1988-1995, 1 (1997).

III. THE SOLUTION TO AMERICA'S DRUG PROBLEM IS THE BALANCED APPROACH EMBODIED IN OUR NATIONAL DRUG CONTROL STRATEGY

There is no simple solution to America's drug problem. In order to effectively address this problem we must attack both the supply and demand for drugs. Pursuing one of these goals at the expense of the other will only unbalance our efforts and reduce the likelihood of success.[97]

The *National Drug Control Strategy* establishes a multi-year framework to reduce illegal drug use and availability by 50 percent within ten years. If this target is achieved, less than 3 percent of the household population aged twelve and over would use illegal drugs -- the lowest recorded drug-use rate in modern American history. Drug-related health, economic, social, and criminal costs would be reduced commensurately. To achieve this target, the *Strategy* focuses on prevention, treatment, research, law enforcement, protection of our borders, and international cooperation.

The *National Drug Control Strategy* is guided by five goals that cover the three broad aspects of drug control -- demand reduction, supply reduction, and the adverse consequences of drug abuse and trafficking. Reducing the demand for illegal drugs is the centerpiece of our *Strategy*, but supply reduction and consequence management are also critical components of a well-balanced strategic approach to drug control. The five goals reflect the need for prevention and education to protect all Americans (especially children) from the perils of drugs, treatment to help the chemically dependent, law enforcement to bring traffickers and other drug offenders to justice, interdiction to reduce the flow of drugs into our nation, and international cooperation to confront drug cultivation, production, trafficking, and use.

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[97] *Accord,* National Research Council, Assessment of Two Cost-Effectiveness Studies on Cocaine Control Policy (1999) (finding that two separate studies commonly used to justify spending on particular anti-drug efforts at the expense of other anti-drug efforts were both flawed). The National Research Council study commissioned by ONDCP, reviewed the earlier findings of a study by the Institute for Defense Analysis (IDA) on the cost effectiveness of interdiction efforts. The IDA Study has been used by some to advocate dramatically expanded spending on interdiction at the expense of a more balanced approach. Recently, the National Research Council found that the research foundation of the IDA study is inadequate to serve as the basis for sound public policy. The Council also assessed the RAND study, *Controlling Cocaine: Supply Versus Demand Programs*, which concluded that marginal dollars should be spent on treatment rather than supply control. The NRC concluded that while the RAND study serves as an important point of departure for the development of richer models of the market for cocaine, the findings do not constitute a persuasive basis for the formulation of cocaine control policy.

1. Goals of the *1999 Strategy*

Goal 1: **Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.**

Goal 2: **Increase the safety of America's citizens by substantially reducing drug-related crime and violence.**

Goal 3: **Reduce health and social costs to the public of illegal drug use.**

Goal 4: **Shield America's air, land, and sea frontiers from the drug threat.**

Goal 5: **Break foreign and domestic drug sources of supply.**

2. Overview of the Strategy

The *National Drug Control Strategy* takes a long-term, holistic view of the nation's drug problem. The document maintains that no single solution can suffice to deal with the multifaceted issue, that several solutions must be applied simultaneously, and that focusing on outcomes – measured in declining drug use and a lessening of attendant social consequences – can achieve our goals. Our Strategy focuses on those approaches that we know work in reducing drug use.

3. Educating Young People

Our primary focus is on preventing youth drug use. Studies show that attitudes about drugs drive youth drug use rates. Preventing drug use before it starts is more effective and cost efficient than trying to break a person free from an already established addiction. By reaching young people before they try drugs, we can help them reject these deadly substances and go on to full, safe, and productive lives.

Our commitment to prevention is backed by significant resources. With the support of Congress in passing our FY2000 counter-drug budget, we will increase federal drug prevention funds by 55 percent since FY1996.

For example, with the bipartisan support of Congress, we have launched the National Youth Anti-Drug Media Campaign, a five-year $2 billion public-private partnership. The Media Campaign is using the full power of modern media -- from television to the Internet to sports marketing -- to educate children, parents, and other adult influencers about the dangers of drugs. Already, the Campaign is producing results:

- Phase I of the Campaign achieved our objective of increasing awareness. Our evaluation shows that youth and teens demonstrated significant increases in ad recall in the target versus the comparison sites -- youth increases ranged from 11 to 26 percent, teens ranged from 13 to 27 percent. Parents in target sites had an 11 percent gain in awareness of the risks of drugs and said that the Campaign provided them with new information about drugs (a 7 percent increase).
- The Campaign's initial target for "reach and frequency" was to reach 90 percent of our overall teen target audience (young people ages nine to eighteen) with anti-drug messages four times per week.
- The Campaign is already reaching 95 percent of our youth target audience 6.8 times per week.
- With respect to our reach, we are reaching nearly every single American child on a regular basis with anti-drug information. With respect to frequency, we are putting this information in front of them at a rate of roughly twice our goal.
- We are buying advertising in 2250 media outlets nationwide (newspaper, TV, radio, magazines, billboards, movie theaters, and others). By any standard, the Campaign is the strongest multi-cultural communications effort ever launched by the federal government and rivals that of most corporate efforts.
- Among African American youth within the target age audience, we are doing even better -- reaching 95 percent of the young people 7.8 times per week.
- Within the Hispanic youth target group, we are reaching 94 percent of our audience with messages ***in Spanish*** 4.8 times per week -- not to mention the substantial impact of messages in English on bilingual young people.
- The Campaign delivers $33 million worth of anti-drug messages per year to ethnic young people and their adult influencers (e.g., parents, grandparents, coaches, teachers, civic leaders, the faith community, and others).
- We are now developing campaign materials in ten additional languages.
- We are the largest governmental advertiser in African American newspapers and are among the top advertisers on Black Entertainment Television.
- The Campaign's target is a one-for-one match; for every taxpayer dollar we spend, we require an added dollar's worth of anti-drug public service, *pro bono* activity.
- The Campaign's private sector match is now at the 109 percent level (or $165 million) for the broadcast industry (matches of ad time on TV and radio). Overall, the corporate match for all Campaign efforts is at the 102 percent level (or $175.4 million).
- Since last July, over 47,000 thirty second PSAs have run on television and radio because of the Campaign.
- In addition to the *pro bono* match, we have received over $42 million of corporate in-kind support. Companies, such as Gateway and UPS, were quick to join our team.
- Thirty-two network television episodes have aired -- on the shows our young people most watch, using the stars they most know -- that have included the Campaign's strategic anti-drug message points.

- Our corporate efforts are as diverse as the rest of the Campaign. We have productive partnerships in place with BET, Univision, Telemundo, and numerous other specialized ethnic media outlets.

The messages of the Media Campaign serve as a vital counter-force to the pro-drug use messages that buffet our children. For too long, the unfiltered Internet has been the media province of the legalizers.[98] Legalizers not only use the Internet to push their policy views,[99] they also use it, for example, to tell young people specifically where the best drugs can be bought at the best price in their city.[100] Some of these websites even provide young people with direct access to drugs.[101]

However, today, through the Media Campaign, when a young person enters search words that relate to drugs -- from straightforward words like "marijuana" to slang, like "bud" or "stone" -- our advertising messages are keyed to respond with accurate drug prevention information. We are also developing web content that will give young people the information they need about drugs in a manner that is interesting and eye-catching. For example, working with Disney, a leader in reaching young people, we recently launched a new teen anti-drug website.

Our web presence is now substantial enough to balance that of the drug legalization community. For example, our two youth websites, "ProjectkNOw" and "Freevibe.com" have respectively received 4,721,249 and 866,833 page views since each went online. Through web advertising (e.g., Internet "banner" ads) our Campaign has generated 221 million impressions.

Prevention, however, requires more than just mass media messages. Prevention begins with parents and families, and requires the support of schools and communities.
The most important tool we have against drug use is not a badge or a gun, it is the kitchen table. Parents can prevent drug use by sitting down with their children and talking with them -- honestly and openly -- about the dangers of drugs to young lives and dreams. While parents often doubt the impact they have on their children's drug use, the fact is young people listen to their parents. For example, recent study by the Partnership for a Drug-Free America found that

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[98] *See. e.g.,* Christopher Wren, *A Seductive Drug Culture Flourishes on the Internet*, The New York Times, June 20, 1997.

[99] The New York Times has also documented at least one instance where groups promoting legalization called upon their counterparts to attack an anti-drug group by overwhelming its infrastructure through harassment calls. *Id.*

[100] *See* "www.hypereal.org/drugs/price.report/u-index.html".

[101] *See* CESAR, *GHB and GHL: 10 Overdoses Reported in Past 90 Days in Maryland; Drugs Available on the Internet,* April 1999 (reporting sales of GHB and GHL over the Internet, with some of the trafficking websites registering more than 250,000 hits).

65 percent of young people (ages thirteen to seventeen) believe that "a great risk if you use marijuana is upsetting your parents."[102] This same study found that 80 percent of our youth (ages thirteen to seventeen) believe that "an important reason for not smoking marijuana is so that your parents will respect you and will feel proud of you."[103]

To help parents we are reaching out -- across the Internet, in newspapers, on the airwaves, and through community groups -- to provide them with the information they need to be able to help their children make the right decision and stay drug-free. For example, through a Media Campaign alliance with AOL, we have created a Parents Resource Center, that can provide information at the click of the mouse. The Department of Education has also recently published *Growing Up Drug-Free: A Parents Guide to Prevention* to give parents the facts and arm them with what to say to their children.

As part of this comprehensive prevention framework, Secretary Riley has recently sent Congress the Administration's proposal for a revamped Safe and Drug Free Schools Program. If adopted this new program will improve accountability, require schools to adopt programs proven effective, and hold the entire system -- from the federal government to the local school -- accountable for producing real results for our children.

Through the Drug Free Communities Grant Program we are also providing local anti-drug coalitions with support in working to protect young people in their communities from drugs. In the first year of the program we made grants to 92 communities, from across 47 states and the District of Columbia. These groups are helping mobilize grassroots efforts to prevent drug use.

4. Combating Normalization

With attitudes being so critical in shaping drug use trends, it is vital that we ensure that drug taking never is perceived as "normal" behavior that is accepted or even tolerated by our society. The imperative to fight the normalization of drug use has played a critical role in the development of federal policies with respect to both medical marijuana and hemp.

With respect to medical marijuana, the recent Institute of Medicine (IOM) report, *Marijuana and Medicine, Assessing the Science Base*, is the most comprehensive summary and analysis of what is known about the medical use of marijuana.[104] The report emphasizes evidence-based medicine

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[102]Partnership for a Drug-Free America, Parents and Marijuana in the 90s, Partnership Attitude Tracking Study 1997 (1997).

[103]*Id.*

[104]Institute of Medicine, National Academy of Sciences, Marijuana and Medicine: Assessing the Science Base (1999).

(derived from knowledge and experience informed by rigorous scientific analysis), as opposed to belief-based medicine (derived from judgment, intuition, and beliefs untested by rigorous science). ONDCP is delighted that the discussion of medical efficacy and safety of cannabinoids can now take place within the context of science.

The IOM report concludes that there is little future in smoked marijuana as a medically approved medication.[105] Although marijuana smoke delivers THC and other cannabinoids to the body, it also delivers harmful substances, including most of those found in tobacco smoke. The long-term harms from smoking make it a poor drug delivery system, particularly for patients with chronic diseases. In addition, cannabis plants contain a variable mixture of biologically active compounds, therefore they cannot be expected to provide a precisely defined drug effect. Medicines today are expected to be of known composition and quality. Even in cases where marijuana can provide relief of symptoms, the crude plant mixture does not meet this modern expectation. If there is any future in cannabinoid drugs, it lies with agents of more certain, not less certain composition. The future of medical marijuana lies on classical pharmacological drug development.

The study also provides a detailed analysis of marijuana's addictiveness. It concludes that marijuana is indisputably reinforcing for many people. It states that a distinctive marijuana and THC withdrawal syndrome has been identified, but it is mild and subtle compared to the profound physical syndrome of heroin withdrawal. The study notes that few marijuana users become dependent but those who do encounter problems similar to those associated with dependence on other drugs. Slightly more than four percent of the general population were dependent on marijuana at one time in their life. After alcohol and nicotine, marijuana was the substance most frequently associated with a diagnosis of substance dependence.

In response to the study's recommendations that "clinical trials of marijuana use for medical purposes should be conducted," on May 21, 1999, the Department of Health and Human Services (HHS) released new guidance on procedures for the provision of marijuana for medical research purposes.[106] "To facilitate research on the potential medical uses of cannabinoids, HHS has determined that it will make research-grade marijuana available on a cost-reimbursable basis . . ." However, pursuant to this guidance, HHS will only provide research cannabinoids for studies that strictly meet the conditions contained in the guidance, including that such research must: meets good clinical and laboratory research practices; examine the use of cannabinoids only "in the treatment of serious or life threatening condition[s]"; and will address "unanswered scientific questions about the effects of marijuana and its constituent cannabinoids or about the safety or toxicity of smoked marijuana."

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[105] *Id.* at 7.

[106] Department of Health and Human Services, Announcement of the Department of Health and Human Services Guidance on Procedures for the Provision of Marijuana for Medical Research, May 21, 1999.

ONDCP endorses the Department of Health and Human Services' decision to facilitate further research into the potential medical uses of marijuana and its constituent cannabinoids. Such research will allow us to better understand what benefits might actually exist for the use of cannabinoid-based drugs, and what risks such use entails. It will also facilitate the development of an inhaler or alternate rapid-onset delivery system for THC or other cannabinoid drugs. Advisors to both the National Institutes of Health and the Institute of Medicine have concluded that such research is warranted. This decision underscores the federal government's commitment to ensuring that the discussion of the medical efficacy and safety of cannabinoids takes place within the context of medicine and science.

Research toward the development of cannabinoid-based medicines is a medical and scientific question that America's health and science establishment must address. However, there are those who want to use medical marijuana as a wedge issue to drive open a hole in counter-drug programs. For example, Richard Cowan, a member of the Advisory Board of an advocacy group called the "Drug Policy Foundation," in 1995 stated: "Key to legalization is medical access [to marijuana] because once you have hundreds of thousands of people using marijuana medically under medical supervision, the whole scam is going to be blown. Once there is medical access and we continue to do what we have to, and we will, we'll get full legalization."[107]

While we must exercise compassion and move ahead with the development of treatments that can relieve human suffering, we cannot and will not allow progress on the medical front to jeopardize the futures of millions of young people.[108] Regardless of developments with respect to the use of cannabinoid-based medicines, we will continue to fully enforce the full range of Federal laws pertaining to the non-medicinal use of marijuana.

We face a similar challenge with hemp. Growing numbers of farmers, rightfully or wrongfully, believe that hemp may offer a new crop that can help the farm economy. However, there are those who want to use de-regulation of hemp to erode America's disapproval of drugs. Still others with criminal intent see hemp as providing a new way to conceal the production of marijuana plants.

If we allow farmers to test the viability of this crop in the marketplace, we must not do so in a manner that allows the normalization of marijuana. Products that market their hemp content with marijuana leaves do so only to sell their products relationship to marijuana. The appeal of these products is not that they are made of hemp but that they are marijuana-related. The hype built

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[107]*See* State of Oregon, Medical Marijuana: A Smoke Screen (1997) (videotape).

[108]The impacts of marijuana use on a child's development are well documented. For example, according to the *National Household Survey on Drug Abuse* child (ages 12 to 17) who regularly uses marijuana is roughly 5 times more likely to assault someone, 6 times as likely to steal, and 6 times as likely to cut classes, as a peer who has never tried the drug.

around these marijuana-related products serves only to glamorize the counter-culture appeal of a drug that has serious consequences for our young people who use it. We cannot allow our policies toward hemp to directly or indirectly increase the use of marijuana among our youth.

America's farmers, who have long been among the most steadfast supporters of our counter-drug programs, will help us police their own. Similarly, ethical farmers seeking solely to make an honest living off a viable legal crop should be more than willing to take the necessary security steps to provide the public with confidence that they are growing hemp and not marijuana.

5. Expanding Treatment

Drug treatment is proven to reduce drug use, drug-related crime, and other related social ills. Studies show that for people who have successfully completed a drug treatment program, even one year after treatment, drug use drops 50 percent, illicit activity falls by 60 percent, drug selling drops by nearly 80 percent, arrests fall by more than 60 percent, homelessness drops by 43 percent, dependence on welfare decreases by 11 percent and employment increases by 20 percent.[109] In short, treatment works.

Our FY2000 counter-drug budget requests $3.5 billion for drug treatment and treatment research programs, representing a 5.5 percent increase from our FY1999 budget. Overall, assuming our FY2000 request is approved, we will increase federal spending on treatment by 25 percent since FY1996. Yet, we still have a long way to go to close the treatment gap. In 1996, approximately 4.4 to 5.3 million people were estimated to need drug treatment.[110] Slightly less than two million people currently receive drug treatment.[111] These figures show that we continue to have a significant treatment gap. Expansion of the Substance Abuse and Mental Health Services Administration's drug treatment and block grant programs, as called for in the Administration's proposed counter-drug budget, will add much needed treatment slots. However, even these gains will not nearly close the current treatment gap.

In a move that will help close this gap, on June 7, 1999, the Office of Personnel Management sent a letter to the 285 participating health plans of the Federal Employee Health Benefits Plan informing them that they will have to offer full mental health and substance abuse parity[112] to

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[109]National Institute on Drug Abuse, Drug Abuse Treatment Outcome Study (1997); Department of Health and Human Services, National Treatment Improvement and Evaluation Study (1996).

[110]ONDCP, *The 1999 National Drug Control Strategy*, at p. 87, n. 19 (1999).

[111]*Id.* at p. 57.

[112]The Administration's goal for the FEHB is to make plan coverage for mental health and substance abuse care identical to traditional medical care with regard to deductibles,

participate in the program. This step will provide full parity for nine million beneficiaries by next year and will ensure that the Federal government leads the way in providing parity.

Additionally, we are developing new guidelines for methadone treatment, which will expand access to this treatment for those who can benefit from it. These new guidelines will also improve the quality of methadone treatment programs by shifting them to a clinic-based modality. Properly administered, methadone treatment can offer drug-addicted people an important bridge to a drug-free lifestyle. By expanding and improving on existing methadone treatment programs we can offer addicted individuals the hope of a brighter, more productive, drug-free future.

6. Breaking the Cycle of Drugs and Crime

Drug dependent people are responsible for a disproportionate amount of our nation's crime. According to the 1998 ADAM report, roughly two-thirds of adult arrestees and more than one-half of juvenile arrestees tested positive for at least one illicit drug.[113] In 1997, one-third of state prisoners and about one-in-five federal prisoners said they had committed the offense that led to their imprisonment while under the influence of drugs.[114] Nineteen percent of state inmates said they perpetrated their current offense leading to incarceration in order to obtain money to buy drugs.[115]

Drug-law offenders are filling our nation's prisons and imposing tremendous correctional costs on our society. The nation's incarcerated population is now over 1.8 million people. Under the present system, far too many addicted individuals enter the cycle of drugs, crime, and prison only to spend the rest of their lives caught in this cycle.

We cannot arrest our way out of our nation's drug problem. We need to break the cycle of addiction, crime, and prison through treatment and other diversion programs. It costs the American taxpayer $25,000 a year to imprison a drug-addicted criminal.[116] By comparison, a year of outpatient treatment costs less than $5,000, and the cost of even more comprehensive residential treatment programs range from $5,000 to $15,000 per year.[117] Evidence also shows

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coinsurance, copayments, and day and visit limitations.

[113] *See* Arrestee Drug Abuse Monitoring Program, National Institute of Justice, 3 (1998).

[114] Christopher Mumola, *Substance Abuse Treatment, State and Federal Prisoners, 1997*, (1999) (published by the Bureau of Justice Statistics).

[115] *Id.*

[116] *Id.*

[117] *Id.*

that drug treatment programs are effective at reducing crime. For example, treatment programs administered by the Delaware Department of Corrections have reduced the recidivism rate for drug-related crimes by 57 percent.[118] Birmingham, Alabama's "Breaking the Cycle" program is also producing promising results. Since its inception in June of 1997, two thousand offenders successfully completed this program as a condition of their release. To date, their rearrest rate is about 1 percent.[119] Breaking the cycle -- through diversion programs and treatment -- is not soft on drugs, it is smart on defeating drugs and crime.

In 1991, the number of federal inmates receiving substance abuse treatment numbered only 1,236. By 1998, that number reached 10,006. While this is a substantial step forward, it is still only a first step. We estimate that the number of arrestees who require drug treatment may be as high as two million a year.[120] If we are to reduce the burdens of drugs and crime on our nation, we need to expand dramatically the treatment opportunities in the criminal justice system.

Similarly, we also need to expand the number of drug courts, which offer nonviolent drug-law offenders supervised treatment in lieu of jail. Defendants who complete a drug court program either have their charges dismissed or probation sentences reduced. In 1994, there were roughly a dozen drug courts nation-wide. In October 1998, 323 drug courts were operating nationwide, and more than two hundred were in planning stages.[121] Even with their growing numbers, today's drug courts still only reach 1 to 2 percent of the population of nonviolent drug offenders.[122]

Our long-term focus on expanding programs in both these areas is reflected in the Administration's counter-drug budget before the Congress at the time of this writing. The Administration's FY2000 request seeks an additional $100 million to provide drug abuse assistance to state and local governments in developing and implementing comprehensive systems for drug testing, treatment and graduated sanctions for drug offenders. The request also seeks an added $10 million for drug court programs, to bring the total support for these programs to $50 million in FY2000.

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[118]James Inciardi, *et al., An Effective Model of Prison-Based Treatment for Drug-involved Offenders,* 2 Journal of Drug Issues 261-278 (1997).

[119]ONDCP, *The 1999 National Drug Control Strategy*, at p. 64 (1999).

[120]*Id.* at p. 63.

[121]*Id.* at p. 64.

[122]*Id.*

7. Helping Communities Fight Drugs

The High Intensity Drug Trafficking Area (HIDTA) program provides assistance to regions of the nation with critical drug trafficking problems that impact wider areas of the nation. HIDTA funds support expanded cooperation between federal, state and local law counter-drug enforcement authorities. HIDTAs strengthen America's drug control efforts by forging partnerships among federal, state and local agencies; and facilitating cooperative investigations, intelligence sharing and joint operations. There are presently 21 HIDTAs. Through funds provided by the Congress in our current budget, soon we will announce the creation of five new HIDTAs.

Local counter-drug law enforcement also benefits greatly from federal efforts to increase the number of police officers on our streets and better equip them to combat today's high-technology drug traffickers. The Community Oriented Policing Services program, known as COPs, has funded over 92,000 new and redeployed police officers to help protect our communities and streets. Through the work of the Counter-drug Technology Assessment Center (CTAC) we are also helping local law enforcement authorities obtain the most up-to-date drug fighting tools.[123]

8. Strengthening the Southwest Border

The shared two-thousand-mile border with Mexico attracts drugs and provides Mexican drug traffickers ample opportunity to move large quantities of heroin, cocaine, marijuana, and methamphetamine into the U.S. Drug violence spills over this border into the neighboring states -- New Mexico, California, Texas, Arizona. Drugs that cross this border pass into our heartland (into Kansas, Iowa, Illinois) and beyond (Massachusetts, New York, Oregon) and attack cities, suburbs, and rural communities alike.

Improving our counter-drug efforts along this border first requires us to better organize our existing efforts. We need to improve our chain of command and accountability for programs in this region. Our Southwest Border programs must also become more flexible and intelligence-driven. We need to better understand the emerging threats and deploy our resources to counter these threats.

We also must shift from a system that is dependent upon manpower to one that relies on cutting-edge technology. We simply cannot think that in an era of expanding interchange that we will be able to unpack every crate of carrots or search every railcar by hand. We need to develop and deploy a family of complementary systems within the next five years that can inspect increasing numbers of in-bound containers, shipments, and conveyances for drugs. We want to provide major ports of entry with the capacity to subject in-bound shipments to non-intrusive inspections

[123]On the demand-side, CTAC technology development efforts are also at the forefront of efforts to better understand the disease of addiction and to develop cures for drug problems.

by complementary systems. Through technology, we shall put in place a seamless curtain against drugs. This curtain will not be iron but information -- derived from technology and intelligence. It will be held in place by good organization and shared commitment -- a commitment based on common values and interests. It will be permeable to trade and culture but impermeable to drugs, crime, and violence.

9. Attacking Drugs in the Transit Zone

Transit zone interdiction plays a critical supporting role to source county programs. Transit zone interdiction programs remove significant amounts of illicit drugs from the pipeline each year that would otherwise reach the United States. These efforts also raise the costs and risks to traffickers of moving cocaine into the United States. Additionally, interdiction operations in the transit zone produce information that can be used to attack trafficking organizations, thereby strengthening the overall U.S. law enforcement effort against international crime. Transit zone interdiction programs reinforce international, bilateral, and regional cooperation against the threat of illegal drugs and strengthen the capabilities of transit nation law enforcement institutions.

Drug traffickers are adaptable, reacting to interdiction successes by shifting routes and changing modes of transportation. Large international criminal organizations have extensive access to sophisticated technology and resources to support their illegal operations. The United States must surpass traffickers' flexibility, quickly deploying resources to changing high-threat areas. Consequently, the U.S. government designs coordinated interdiction operations that anticipate shifting trafficking patterns.

Drugs coming to the United States from South America pass through a six-million square-mile transit zone that is roughly the size of the continental United States. This zone includes the Caribbean, Gulf of Mexico, and eastern Pacific Ocean. The Coast Guard is the lead federal agency for maritime interdiction and co-lead with U.S. Customs for air interdiction. The interagency mission is to reduce the supply of drugs from source countries by denying smugglers the use of air and maritime routes in the transit zone. In patrolling this vast area, U.S. federal agencies closely coordinate their operations with the interdiction forces of a number of nations. In 1998, roughly eighty metric tons of cocaine were seized in the transit zone.

Stopping drugs in the transit zone involves more than intercepting drug shipments at sea or in the air. It also entails denying traffickers safe haven in countries within the transit zone and preventing their ability to corrupt institutions or use financial systems to launder profits. Consequently, international cooperation and assistance is an essential aspect of a comprehensive transit zone strategy. Accordingly, the United States is helping Caribbean and Central American nations to implement a broad drug-control agenda that includes modernizing laws, strengthening law-enforcement and judicial institutions, developing anti-corruption measures, opposing money laundering, and backing cooperative interdiction.

The Caribbean Violent Crime and Regional Interdiction Initiative will expand counter-drug operations targeting drug trafficking-related criminal activities and violence in the Caribbean region including South Florida, Puerto Rico, the U.S. Virgin Islands, and the independent states and territories of the eastern Caribbean. This initiative will implement mutual cooperative security agreements between the United States and Caribbean nations, implement commitments made by the U.S. President during the Caribbean Summit held in Barbados in May 1997, develop regional maritime law enforcement capabilities; increase the capability of Caribbean nations to intercept, apprehend, and prosecute drug traffickers through modest expansion of training, equipment upgrades and maintenance support, and institutionalize the Americas Counter Smuggling Initiative (ACSI) to provide at-risk commercial carriers, industry, and government offices with training to prevent goods and conveyances from being used to smuggle illegal drugs.

Nonetheless, traffickers have demonstrated that they can absorb interdiction losses in the transit zone as the cost of doing business while increasing source country cultivation and production to make up interdiction losses. In the transit zone, traffickers have the initiative and can choose when, where, and how to challenge interdiction forces. They are able to alter routes and methods in response to effective law enforcement interdiction activity. Transit zone operations will be most effective when source country programs are able to effectively constrain drug production potential, preventing trafficking organizations from making up interdiction losses.

10. Building International Cooperation

The United States continues to focus international drug control efforts on supporting the critical work of drug source countries. International drug trafficking organizations and their production and trafficking infrastructure are most concentrated, detectable, and vulnerable to effective law enforcement action in source countries. The coca and opium poppy growing areas are easily detectable and relatively fixed. The cultivation of coca and opium poppy and production of cocaine and heroin are labor intensive and can be disrupted by concerted law enforcement action.

To be successful on the scale necessary to disrupt the illegal drug industry, drug source countries must have control of growing areas, adequate law enforcement resources, capabilities, and the will to confront a sometimes politically powerful segment of the population or one that is protected by well-armed and well-equipped insurgent groups. The international drug control strategy seeks to bolster source country resources, capabilities, and political will to reduce cultivation, attack production, and disrupt and dismantle trafficking organizations, including their command and control structure and financial underpinnings. Our actions focus on assisting the host nation expand law enforcement control over drug crop growing areas, reestablish the rule of law, and eliminate illegal drug crops in ways that protect human and democratic rights. The political will and long-term commitment of these other nations are critical to our common success against drugs.

These international efforts are making a difference, for example:

- Cocaine production in Bolivia and Peru has dropped by 300 metric tons over the last four years.[124]
- Coca cultivation in Peru has plunged 56 percent from 115,300 hectares in 1995 to 51,000 hectares in 1998.[125]

CONCLUSION

Here at home, in the last two years, youth drug use rates have leveled off and in many cases are now in decline (this marks a sharp departure from the prior six years, which saw the number of our children doing drugs steadily increase). Overall drug use in the United States is now half what it was in the 1970s. During this same period cocaine use has fallen by 75 percent. Drug-related murders have reached their lowest point in over a decade.

On the international front, cocaine production in Bolivia and Peru has decreased by 300 metric tons over the last four years. We have built a common consensus against drugs. We have eliminated the distinction between producer and consumer nations, and built a common understanding that drugs threaten all nations. Working with the rest of the international community we have built strong counter-drug cooperation through the United Nations, and within this hemisphere through the Organization of American States.

These advances provide a solid foundation upon which to build. Clearly, the answer is not to make dangerous, addictive substances more available or to drop our societal guard. Instead, we must focus on prevention, treatment, enforcement, interdiction and international cooperation. In other words, we must remain focused on those things that we know work.

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[124]CIA Crime and Narcotics Center, unpublished data (1999).

[125]Department of State, International Narcotics Strategy Report, 22 (1999).

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EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
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Biographic Summary of Barry R. McCaffrey
Director, Office of National Drug Control Policy

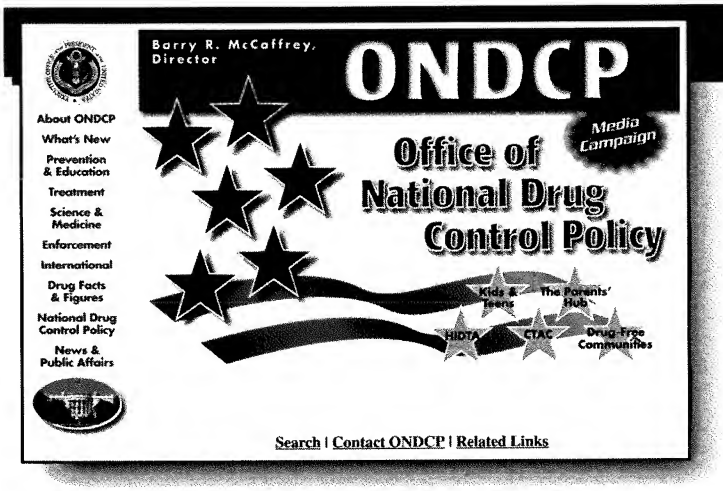
Barry McCaffrey was confirmed by unanimous vote of the U.S. Senate as the Director of the White House Office of National Drug Control Policy (ONDCP) on 29 February 1996. He serves as a member of the President's Cabinet, the President's Drug Policy Council, and the National Security Council for drug-related issues. By law, the Director certifies the $17.8 billion federal drug control budget and develops the *U.S. National Drug Control Strategy*.

Barry McCaffrey graduated from Phillips Academy in Andover, Massachusetts and the U.S. Military Academy. He holds a Master of Arts degree in civil government from American University and taught American government, national security studies, and comparative politics at West Point. He attended Harvard University's National Security Program. He is a member of the Council on Foreign Relations and an associate member of the Inter-American Dialogue.

Among the honors he has received are: the Department of State's Superior Honor Award for the Strategic Arms Limitation Talks; the Norman E. Zinberg Award of the Harvard Medical School; the Founders Award of the American Academy of Addiction Psychiatry; the NAACP Roy Wilkins Renown Service Award; the National Drug Prevention League National Leadership Award; the U.S. – Panama Business Council Friendship Award; and decorations from France, Brazil, Argentina, Colombia, Peru, and Venezuela.

Prior to confirmation as ONDCP Director, he was the Commander-in-Chief of the U.S. Armed Forces Southern Command coordinating national security operations in Latin America. During his career, he served overseas for thirteen years, which included four combat tours: Dominican Republic, Vietnam (twice), and Iraq. At retirement from active duty, he was the most highly decorated and youngest four star general in the U.S. Army. He twice received the Distinguished Service Cross, the nation's second highest medal for valor. He also was awarded three Purple Heart medals for wounds sustained in combat. During Operation Desert Storm, he commanded the 24th Infantry Division and led the 370-kilometer "left hook" attack into the Euphrates River Valley. General McCaffrey served as the JCS assistant to General Colin Powell and supported the Chairman as the staff advisor to the Secretary of State and the U.S. Ambassador to the United Nations.

Barry McCaffrey has been married for thirty-four years to the former Jill Ann Faulkner. She serves as National Chairman for the Armed Forces Emergency Services of the American Red Cross and is a member of the Board of Directors for Knollwood - The Army Distaff Hall. The McCaffreys have three married children: Sean, a U.S. Army infantry Major; Tara, an intensive care nurse and a U.S. Army Washington National Guard Captain; and Amy, a seventh grade school teacher.



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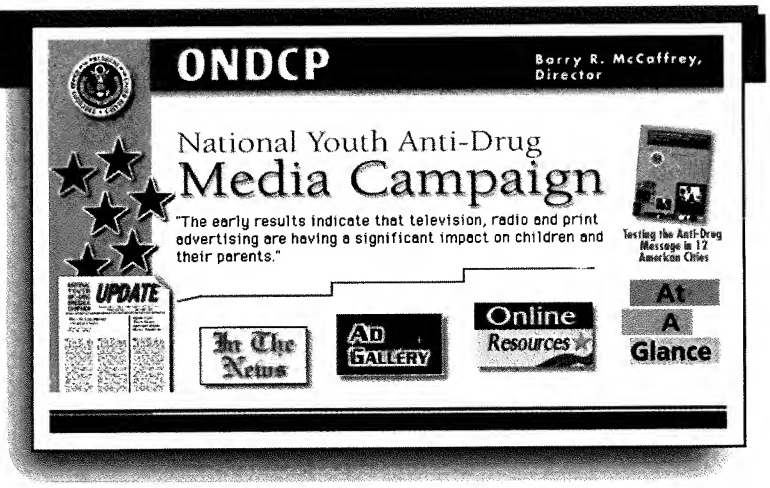

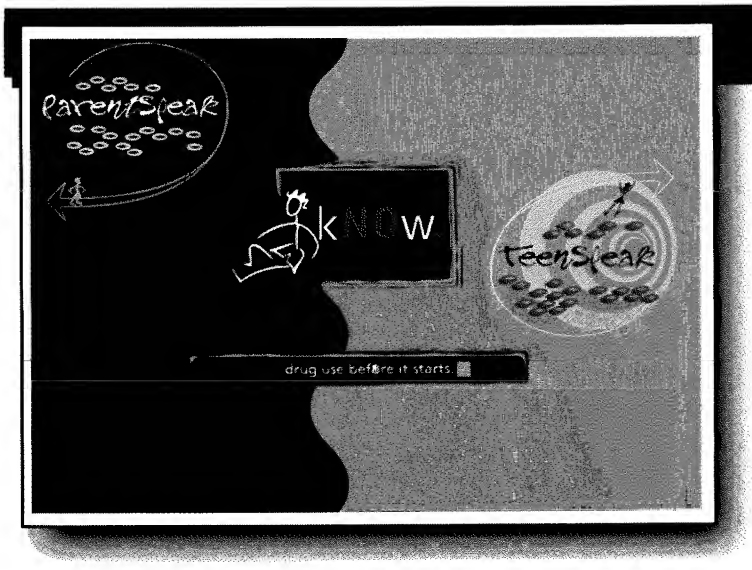

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